INLAND COUNTIES EMERGENCY MEDICAL AGENCY

EMS Newsletter

Serving Inyo, Mono & San Bernardino Counties September/October 2004

ICEMA

2004-2005 EXAM DATES

EMT-Ps AND MICNs

The testing dates below apply to all EMT-Ps and MICNs for initial accreditation/certification, and for those EMT-Ps and MICNs who choose the testing option to maintain their accreditation or certification.

DEADLINE TO APPLY	WRITTEN EXAM DATE
OCTOBER 5, 2004	OCTOBER 19, 2004
NOVEMBER 2, 2004	NOVEMBER 16, 2004
DECEMBER 7, 2004	DECEMBER 21, 2004
JANUARY 4, 2005	JANUARY 18, 2005
FEBRUARY 1, 2005	FEBRUARY 15, 2005

In This Issue

REMEMBER ICEMA ON THE WEB AT ICEMA.net

AED SUCCESS

By Captain Art Andres, EMS Coordinator
Ontario Fire Department

On July 11th at 20:59, Ontario Airport Police Officer James Drummond responded to an unresponsive person in the airport terminal. Upon his arrival, he found a 70 year old female pulseless and apneic. Ontario Airport Police Officer, Joshua Ulatowski, who helped perform CPR, soon joined Officer Drummond. They were quickly assisted by Airport Safety Officers(ASO), Randy Lovins and Brent McClure who applied an AED which advised a shock was indicated. The patient was defibrillated as indicated by the AED before the arrival of Ontario City Fire Department ME 138; Captain Kurt Hager, Engineer Hal Basenburg, Firefighter/Paramedic Bryan Ruppert and Firefighter/Paramedic Shane Sherwood. ME 138 paramedics shocked the patient 2 additional times before the patient regained a carotid pulse at 140 bpm. The patient was intubated with a 7.5 oral ET and had a pulse ox of 99%. An IV was established and a 500 cc fluid challenge was administered after obtaining a blood pressure of 60 systolic. The patient's blood pressure increased to 130 systolic and had a pulse of 100bpm. Upon arrival at San Antonio Community Hospital, the patient was opening her eyes and attempting to pull her ET tube out.

Virginia Smith, PLN at San Antonio Hospital, stated the patient was extubated prior to being admitted to the hospital and was alert, orientated, and unable to recall the event but had no other neuro deficit.

Early intervention by Ontario Airport Fire first responders, followed by advanced life support by Ontario Fire Department paramedics is a perfect example of how pre-hospital emergency medicine can and does make the difference in the lives of the people they serve.

SEEING-EYE DOGS ACCOMPANY PATIENTS IN AMBULANCES

ICEMA's position regarding allowing a seeing-eye dog to accompany a patient during transport reflects the position of hospitals and other health care facilities. The seeing-eye dog is an integral part of the individual's lifestyle and must be allowed to accompany a patient during transport.

BLS CORNER

by Dell James, R.N.
BLS Coordinator

Effective Monday, August 2nd, 2004, San Bernardino County Fire Station 43, (Johnson Valley) South Desert Division, officially went "on-line" with their AED Program. Station 43's Paid Call Firefighter's (PCF's) and citizen volunteers, along with PCF's from Station 22 personnel recently completed their AED training during the month of June. Station 43 recently received their donated FR-2 AED unit from San Bernardino County Board of Supervisor, Dennis Hansberger's office during that same time frame. Station 43 now joins the other South Desert AED's stations bringing the total to 8 - AED's unit now in usage. The Department now has 29 AED station providers. A total of 37 AED units are available for use department wide. Thanks to John Commander for the information.

ALS CORNER

by Sarah Momsen, R.N.
ALS Coordinator

The following twenty protocols were reviewed at EMCC meetings held in all three counties in July and September and subsequently approved by Dr. Salinas. These protocols will become effective on November 1, 2004. They will be placed on the ICEMA web site at *www.icema.net* prior to October 1, 2004.

Reference #2001 Standard Drug and Equipment List – This protocol has undergone a total format revision and now includes BLS transport as well as ALS transport & non-transport recommendations.

Reference #4035 Axial Spinal Stabilization –The name of this protocol has been changed from Axial Spinal Stabilization. Minor wording changes have been made under ALS Interventions to clarify the indications for patient removal from Axial Spinal Immobilization.

Reference #5007 Altered Level of Consciousness/Seizures – This protocol combines Reference #s 5005 Seizures and 5007 Altered Level of Consciousness into one protocol. The Field Assessment/ Treatment Indicators reflect this combination.

Reference #5018 Heat Related Emergencies – This protocol moves Reference #10007 Hyperthermia into the Medical Emergency Series and changes the name. This protocol has undergone extensive revision and discusses treatment for Minor Heat Illness Syndromes, Heat Exhaustion and Heat Stroke.

Reference #7007 Pediatric Altered Level of Consciousness (Birth – 14 Years of Age) – This is a new protocol addressing the treatment of the altered patient under 15 years of age.

Reference #7008 Pediatric Respiratory Emergencies (Birth – 14 Years of Age) – This is a new protocol addressing the treatment of the respiratory patient under 15 years of age.

Reference #7010 Pediatric Seizure (Birth – 14 Years of Age) – This is a new protocol addressing the treatment of seizures in this age group.

Reference #7011 Pediatric Allergic Reaction (Birth – 14 Years of Age) – This is a new protocol addressing the treatment of an allergic reaction in this age group.

Reference #8001 Adult Trauma – This protocol has been revised and addresses trauma treatment of the adult patient. This new protocol also includes burn management treatment modalities.

Reference #8003 Pediatric Trauma (Birth – 14 Years of Age) – This protocol addresses trauma treatment of the pediatric patient from birth to 14 years of age. This new protocol also includes burn management treatment modalities.

Reference #8010 Adult Trauma Triage Criteria – Although this is a relatively new protocol, it was brought back for comment because of changes recommended by the Trauma Advisory Committee.

Reference #8012 Pediatric Trauma Triage Criteria – Although this is a relatively new protocol, it was brought back for comment because of changes recommended by the Trauma Advisory Committee.

Reference #11001 Newborn Care – This protocol will replace 3 current protocols (Reference #s 11001, 11005 and 11007) into one comprehensive protocol. Additionally this protocol reflects our new format.

Reference #12001 Medical Response to a Multi-Casualty Incident – This protocol has been revised to provide a written guideline to assist EMS personnel in determining if a MCI exists, and to provide general guidelines in handling the incident consistent with the Incident Command System (ICS).

Reference #14001 Physician on Scene – This protocol is designed to establish criteria for an EMT-Paramedic during situations in which a physician is physically present on the scene of a medical or trauma emergency. This protocol was last reviewed in 2000.

Reference #14002 Suspected Sudden Infant Death Syndrome Incident – This was last reviewed in 2000 and provides direction for ICEMA pre-hospital personnel to assist the caregiver and local police agencies during a suspected SIDS Incident.

Reference #14003 Responsibility for Patient Management – This protocol defines the responsibility for patient health care management in an emergency. This protocol was last reviewed in 2000.

Reference #14004 Reporting Incidents of Suspected Abuse/Neglect – This protocol was last reviewed in 2000 and addresses the mandated reporting requirements of pre-hospital personnel.

(continued on page 4)

ALS Corner

(continued from page 3)

Reference #14007 Determination of Death on Scene – This protocol was last reviewed in 2000 and has been revised according to our new format. Additionally, we have clarified situations when pre-hospital providers shall make base hospital contact.

Reference #14009 Radio Communication – This protocol attempts to define the requirements for medical communication between prehospital personnel, base and receiving hospitals. This protocol was last reviewed in 1999. It has been extensively revised.

TWO LOCALS RECEIVE SPECIAL RECOGNITION FROM AMERICAN MEDICAL RESPONSE

The world of EMS often involves collaboration with many other Public Safety agencies. The most successful results occur when these agencies demonstrate teamwork in tackling overwhelming challenges. During EMS Week in May, two of our local providers were honored at an awards ceremony in Natick, Massachusetts.

Steve Myers has been with AMR and its predecessor companies since 1982, working in several positions including EMT, Paramedic, Communications Dispatcher, Operations Supervisor, Business Development Specialist, and now his current position as an AMR Driver Development Specialist. Steve has had a lot of experience responding to disaster situations, such as the Cerritos Air disaster in 1986, L.A./King civil unrest in 1992 and the Northridge earthquake in January 1994.

Richard Rolston is the EMS Division Chief for the Big Bear City Fire Department. He has been a paramedic now for over 25 years. He also serves as the Chairman of the Board for Bear Valley Community Hospital. He was the Emergency Operations Center Coordinator for the Big Bear Valley during the October 2003 fires. During this time he oversaw the evacuation of Big Bear Valley, closed it's hospital and prepared for the worst. Chief Rolston was in constant communication with many different AMR representatives, including field personnel, supervisors and managers. AMR had ambulance strike teams in Big Bear, many led by Steve, to enter into the fire zones and evacuate mountain residents and assist the Fire Department in countless 911 calls.

Together, Richard Rolston and Stephen Myers represent the best in public safety teamwork. In honor of all the Fire and EMS professionals that worked hand in hand to suppress those widespread fires, we would like to congratulate both of them on their much-deserved recognition.

NIAID EXPANDS WEST NILE VIRUS TREATMENT TRIAL

The National Institute of Allergy and Infectious Diseases,one of the National Institutes of Health, has expanded its clinical trial of an experimental West Nile virus (WNV)treatment to about 60 sites throughout the United States and Canada. The multicenter trial, which opened at 36 sites, last September, is expected to add about 24 new sites this summer, pending internal approval at each institution. A listing of all sites is available at <*http://www.casg.uab.edu/adult/act%20210WNV.htm*>.

The study is testing the safety and preliminary effectiveness of using a product containing WNV infection- fighting proteins, or antibodies, to treat people whose infection has reached or threatens to reach the brain.

"As West Nile virus disease continues to spread across our country, it is critical that we develop specific treatments for its most severe symptoms," says Anthony S. Fauci, M.D.,NIAID director. "At present, clinicians have few options besides supportive care for treating people with WNV illness. By expanding this study, we hope to accelerate NIAID's efforts to understand, develop treatments for and eventually prevent this disease."

Until recently, human infection with West Nile virus, which is spread by mosquitoes, was limited to Africa, Asia and the Middle East. Since its arrival in the New York City area in 1999, human WNV infection has increased in scope and severity in the United States each year. In 2003, the U.S. Centers for Disease Control and Prevention reported more than 9,860 cases of WNV disease, which included 264 deaths.

(continued on page 5)

NIAID Expands WNV Trial

(continued from page 4)

The main goal of this study, notes Walla Dempsey, Ph.D., who oversees NIAID's WNV clinical trial contracts, is to assess the safety of a blood plasma-derived substance containing WNV antibodies when given intravenously to patients with WNV infection. Secondarily, she adds, the study seeks preliminary data about the treatment's effectiveness against encephalitis, a brain inflammation caused by WNV infection.

"Information from this study will enable us to better characterize the clinical course of West Nile virus infection," Dr. Dempsey says, "which in turn will allow us to design more meaningful clinical trials in the future."

ON-LINE ACLS RECERTIFICATION

ACLS and PALS on-line recertification courses will not be accepted by the State EMS Authority as meeting the Paramedic continuing education requirements. The State EMS Authority cites the following reasons for not accepting this form of continuing education:

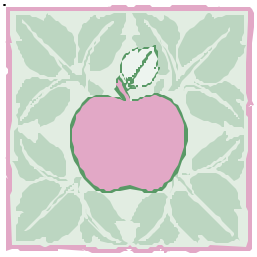
- The courses do not have a provision for conducting skills testing as a measure of competency
- The courses are not taught by a CE Provider approved pursuant to the Paramedic Regulations

If you have any questions, please contact the State EMS Authority - Paramedic Licensure Division at (916) 323-9875.

STAYING WELL

An apple a day...

Folklore claims that an apple a day keeps the doctor away, and it seems that's not far from wrong. At least it seems true for men.



According to The American Journal of Clinical Nutrition, a Finnish study shows that men who ate the most apples and other foods high in quercetin had 60 percent fewer cases of lung cancer, 25 percent less asthma, and 20 percent less diabetes and heart disease.

Researchers at the National Public Health Institute in Helsinki say eating an apple a day is enough to get these benefits. Other foods rich in quercetin are onions, cabbage, and berries.

HOW ATROPINE WORKS AGAINST BRONCHOSPASM

Atropine and Atrovent: Anticholinergic Therapy for Bronchoconstriction

Anthony Ricci, FAE-Paramedic

Anti-cholinergic therapies for bronchoconstriction are widely used but poorly understood. ICEMA EMT-Paramedics are allowed to administer one anti-cholinergic medication (400ug atropine sulfate) as part of a bronchodilatory regimen. Another anti-cholinergic medication that may become available to ICEMA pre-hospital care providers is Atrovent. The following article will give a greater understanding on exactly how these medications work.

A Bit of A & P: The parasympathetic nervous system plays a major role in regulating airway homeostasis and bronchomotor tone. Increased parasympathetic activity can result in bronchostriction. Vagal nerve fibers that end on muscarinic [i.e., parasympathetic] receptors innervate the larger airway smooth muscles while beta-2 receptors innervate the smaller smooth-muscled bronchioles.

Anticholinergic [Atropine, Atrovent] agents are competitive inhibitors of acetylcholine at the muscarinic receptors and are effective in relieving cholinergic-mediated bronchoconstriction.[1]

A Quick Review: Bronchoconstriction, or narrowing of the bronchioles, is a condition often encountered by paramedics in the pre-hospital setting. The causes are many and include asthma, infection, and certain types of reactive airway disease (allergic & idiopathic).

Treatment Options: The acute case of bronchoconstriction can be generally divided into two categories: anti-inflammatory and bronchodilatory.

Anti-inflammatory drugs decrease the cellular response of inflammation and include various types of corticosteroids, mediator-release inhibitors, and anti-leukotriene drugs.[2]

Unless transport times are very long, anti-inflammatory drugs are generally not used in the pre-hospital setting because they can take 30 minutes or more to work (depending on route of administration).

(Continued on page 6)

ATROPINE (Continued from page 5)

Bronchodilator drugs exist in abundance. Bronchodilator drugs work by relaxing the smooth muscle in the airways. Below are listed some of the bronchodilator drugs:[3]

1. Beta-adrenergics

a. Inhaled:	epinephrine (Primatene Mist), isoproterenol, albuterol, terbutaline
b. SQ:	epinephrine, terbutaline
c. Oral:	albuterol, terbutaline, ephedrine

2. Methylxanthines

a. Oral:	caffeine, theophylline, oxtriphyline
b. Intravenous:	aminophylline

3. Anti-cholinergics

a. Inhaled:	atropine, ipratropium bromide (Atrovent), albuterol & atrovent (Combivent)

Bronchodilation via beta-2 adrenergic medication administration is common in pre-hospital care. Nebulized albuterol and SQ epinephrine are standard modalities. Adding anti-cholinergic therapy to initial care may enhance patient response to treatment in a "one-two punch" effect as bronchodilation would be accomplished via beta-2 agonism and simultaneous anti-cholinergic effect. A study published in the British Medical Journal showed a promising 30% reduction in hospital admission rates when multiple doses of anti-cholinergics were added to standard beta-2 adrenergic nebulizer therapy. [4]

Anti-cholinergic medications take longer to work and affect the larger airways, thus, early administration along with a beta-2 agonist is more effective than waiting until just before pulling into the hospital emergency medical department parking lot.

Atropine, the only anti-cholinergic bronchodilatory drug currently in our pre-hospital toolbox, is an effective bronchodilator. We know that atropine is one of the first-line agents against organophosphate or nerve agent intoxication. What is less known is that it is one of medicine's oldest bronchodilators. Until the first medical atomizer was introduced in 1938, the only way to generate an aerosol was to burn medicinal powders, or inhale smoke from cigarette papers impregnated with Belladonna [natural source of atropine) and other ingredients, so called "asthma cigarettes." [5,6]

A common misconception is that when atropine is used for bronchodilation its therapeutic benefits are based upon its "drying" effects. In fact most sources consider the modest drying effect of atropine to be an adverse affect.[7] This side effect of atropine can be helpful in conditions where copious secretions are problematic, i.e., organophosphate or nerve agent toxicity. In these cases the doses of atropine are very large and can easily exceed 30 milligrams (mgs) compared to either the 400ug (0.4mg) nebulized dose, or the 500ug-1mg (0.5-1mg) IV doses routinely given for cardiac purposes in pre-hospital care.

Since bronchial drying can be detrimental in cases where increased mucous plugging and viscosity are problems, e.g. exacerbations of asthma and bronchitis, atropine is given via nebulizer to minimize this effect. Nebulized atropine acts mainly topically and blocks the effects of acetylcholine on the smooth muscles of the larger airways. This cholinergic blockade results in bronchodilation. As an interesting side note, at least one study showed that the combination of inhaled and IM atropine had the greatest bronchodilatory effect and the greatest protection against exercise-induced bronchoconstriction. The hypothesis supported was that inhaled atropine [alone] could not reach all the airways where cholinergic receptors are present.[8]

Atrovent, a quaternary derivative of atropine, has fewer side effects than atropine. Atrovent's side effects are limited by its having a chemical "anchor" that limits its absorbability through the mucous membranes of the body. Its most common reported adverse effects are, as with atropine, dry mouth, blurred vision, and drying of secretions. Due to the greater localization of its anti-cholinergic effects and safe track record, the use of Atrovent is becoming more and more widely used pre-hospital EMS systems.

In conclusion, our treatment of bronchoconstriction is still basic but effective. As paramedics making initial contact, we have effective means of relieving bronchospastic respiratory distress. The early combination of multiple-dose anti-cholinergic regimens in the initial treatment of adults and children has led to an important reduction in hospital admission rates.[9,10,11,12] Using the combination of albuterol and early use of an anti-cholinergics (atropine or hopefully one day soon, Atrovent), bronchoconstriction can be more effectively relieved, and the patient's distress thus mitigated.

(Continued on page 7)

ATROPINE *Continued from page 6)*

(Footnotes)

[1] Robert G Aucoin, RPh, Respiratory Pharmacotherapy / Anticholinergics, Our Lady of the Lake Regional Medical Center, Baton Rouge, LA, USA, 1999 (http://pedsccm.wustl.edu/All-Net/english/pharmpage/resp/antichol.html)

[2] Lawrence Martin, MD, FACP, FCCP, Drugs for Asthma and COPD, martin@lightstream.net, 2002

[3] Lawrence Martin, MD, FACP, FCCP, Drugs for Asthma and COPD, martin@lightstream.net, 2002

[4] British Medical Journal, Should Inhaled Anticholinergics be added to B_2 agonists for Treating Acute Childhood and Adolescent Asthma? A Systematic Review (1998)

[5] Brown OH. Treatment of asthma. In: Asthma: presenting an exposition of the nonpassive expiration theory. St. Louis, MO: C.V. Mosby; 1917. p. 265-288

[6] Gandevia B. Historical review of the use of parasympatholytic agents in the treatment of respiratory disorders. Postgrad Med J. 1975;51(7 suppl):13-20

[7] Robert G Aucoin, RPh, Respiratory Pharmacotherapy / Anticholinergics, Our Lady of the Lake Regional Medical Center, Baton Rouge, LA, USA, 1999

[8] Chest, Vol 79, 651-656, Copyright © 1981 by American College of Chest Physicians

[9] Braun SR, McKenzie WN, Copeland C, et al. A comparison of the effect of ipratropium and albuterol in the treatment of chronic obstructive airway disease. Arch Intern Med. 1989; 149:544-547.

[10] Easton PA, Jadue C, Dhingra S, Anthonisen NR. A comparison of the bronchodilating effects of a beta-2 adrenergic agent (albuterol) and an anti-cholinergic agent (ipratropium bromide), given by aerosol alone or in sequence. N Engl J Med. 1986;315:735-739.

[11] Summers QA, Tarala RA. Nebulized ipratropium in the treatment of acute asthma. Chest. 1985;88:24-29.

[12] O'Driscoll BR, Taylor RJ, Horsley MG, et al. Nebulised salbutamol with and without ipratropium bromide in acute airflow obstruction. Lancet. 1989;1:1418-1420.

***ICEMA is in the process of getting EMSA approval for use of Atropine in the region. Approval is expected for sometime in 2005.*

TRAUMA CORNER

On June 22, 2004, the Governing Board of Inland Counties Emergency Medical Agency (ICEMA): designated Loma Linda University Medical Center (LLUMC) as a Level 1 Trauma Center (Pediatric) and reaffirmed the Board's prior designation as a Level 1 Trauma Center (Adult). The Board also reaffirmed it's prior designation of Arrowhead Regional Medical Center (ARMC) as a Level II Trauma Center (Adult). ICEMA would like to congratulate both facilities and thank them for their hard work.

AVOID THE HOLIDAY RUSH

With the upcoming holidays quickly approaching, we would like to remind everyone not to wait until the last moment to reapply. Due to the extremely high volume of expirations and reduced office hours during the month of December, please be advised that applications submitted after December 1, 2004 may not be processed by December 31, 2004. Help make everyone's holiday season more enjoyable by applying early and avoiding the rush.

ICEMA will be closed on the following days so that employees can enjoy time with their families:

October 11	December 23
November 11	December 24
November 25	December 30
November 26	December 31

CE Calendar

ICEMA (Inland Counties Emergency Medical Agency) Inyo/Mono/San Bernardino Counties

ARROWHEAD REGIONAL MEDICAL CENTER
Joy Peters, RN, PLN
(909) 580-1845

9/1	Field Care Audits/Lecture	Rialto Fire Dept.
9/15	Skills/Protocol Update Class/FCA	ARMC - 2nd Flr. Anesthesia Conference Room
9/21	Documentation	Barstow Fire Dept.
10/6	ACLS	Rialto Fire Dept.
10/19	Field Care Audit	Barstow Fire Dept.
11/3	Skills/Protocol Update Class	Rialto Fire Dept.
11/9	Trauma Assessment	Barstow Fire Dept.
12/1	Field Care Audits	Rialto Fire Dept.

CENTER FOR HEALTHCARE EDUCATION
(888) 834-8700

9/28-29	BLS Instructor Workshop	San Bernardino
9/30	First Aid Instructor Workshop	San Bernardino

LOMA LINDA UNIVERSITY MEDICAL CENTER
Davey Ellison, R.N., PLN
(909) 558-8502
www.lluems.com

9/17	Protocol Update Class/Skills	Adelanto
9/21	EMS Lecture/Field Care Audit	SB City Fire St. 221
10/19	EMS Lecture/Field Care Audit	AV Fire St. 336
10/27	Protocol Update Class/Skills	LLUMC
11/16	EMS Lecture/Field Care Audit	SB City Fire St. 221
12/17	Protocol Update Class/Skills	SB City Fire St. 221
12/21	EMS Lecture/Field Care Audit	AV Fire St. 336

LONE PINE FIRE DEPARTMENT
Sandy Manning, R.N, B.S.N.
(760) 876-5581

TBA	Patient Assessment (6-9p)
TBA	Emergency Childbirth (6-9p)

NORTHERN INYO HOSPITAL
Brigette Mosier, R.N.
(760) 873-5811
(Please call to pre-register)

10/4-5	Pediatric Advanced Life Support	Partridge Bldg.
10/17	Basic Dysrythmia	Partridge Bldg.
10/15	Neonatal Resuscitation Renewal Course	Partridge Bldg.
11/1-2	Advanced Cardiac Life Support	Partridge Bldg.

SAN BERNARDINO CITY FIRE DEPARTMENT
Henry Vasquez, EMS Coordinator
(909) 558-7076

9/7	PUC / Skills Day (9-4p)	SMFD Sta. 241
9/21	Lecture / Field Care Audits	SBFD Sta.221
9/28-30	CPR/1st Aid Instructor Training	SM Training Ctr
10/5	ACLS Recert/Skills Day (9-4p)	SMFD Sta. 241
11/2	PUC / Skills Day (9-4p)	LLFD Sta. 251
11/16	Lecture / Field Care Audits	SBFD Sta. 221
11/15-17	CPR/1st Aid Instructor Training	SM Training Ctr
12/6/7	PEPP	SM Training Ctr
12/14	Lecture / Field Care Audits	SBFD Sta. 221

- Classes start at 9am
- Call 384-5386 x 1128 to register for SBFD or LLFD Classes (Leave your name and a number)
- Call 382-2222 x 278 to register for San Manuel classes
- Call Center for Healthcare Education for the CPR/1st Aid Instructor Classes (888) 834-8700 (Tuition charged)

SAN BERNARDINO COUNTY FIRE DEPARTMENT

John Commander, EMS Coordinator

(909) 382-5405

9/1-31	Shock	WVD
9/1-31	Emergency Pharmacology	St. 121
9/6-7-9	Field Care Audits	St. 121
9/14-17	12 Lead EKG	St. 121
9/13	Emergency Care of the Sick/Injured	OFM
9/15	Emergency Care of the Sick/Injured	OFM
9/20	Emergency Care of the Sick/Injured	OFM
9/22	Emergency Care of the Sick/Injured	OFM
9/27	Emergency Care of the Sick/Injured	OFM

USMC- TRAINING COMMAND CENTER

Dennis P. Fleming,EMT-P

(760) 830-6871

9/10	Abdominal Emergencies
9/24	Trauma Emergencies
10/8	AED Review
10/22	Burns
11/05	Behavioral Emergencies
12/3	Neurological Emergencies

INTERNET CES

- www.eminet.com
- www.eme-ce.com
- www.emcert.com
- www.healthcareeducation.org
- www.rcecs.com
- www.CE3000.com

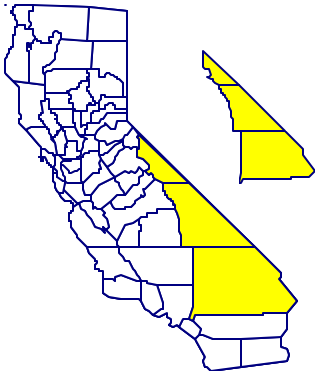
Updated CE Calendars are available online at *icema.net* under Continuing education. the site is updated as information becomes available. Check it out!

Inland Counties Emergency Medical Agency

515 N Arrowhead Avenue

San Bernardino CA 92415-0060

PRESRT STD
U.S. POSTAGE
PAID
San Bernardino, CA
Permit No. 1677



CHANGE OF ADDRESS OR EMPLOYER

Name:_____ Certification #:_____ Expiration Date:_____

Former Address:_____

New Address:_____

Telephone Number: ( ) _____

Previous Employer: _____ Current Employer:_____

Effective Date:_____ Signature:_____

Please mail this form to ICEMA as soon as possible to assure that you continue to receive all appropriate notices. Thank you.